

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to [Section H](#) of the Pharmaceutical Schedule. For community funding, see the [Special Authority Criteria](#).

PRESCRIBER

Name:

Ward:

PATIENT:

Name:

NHI:

Ambrisentan

INITIATION

Prerequisites (tick boxes where appropriate)

- For use in patients with a valid Special Authority approval for ambrisentan by the Pulmonary Arterial Hypertension Panel
- or
- In-hospital stabilisations in emergency situations

HOSPITAL

I confirm that the above details are correct:

Signed: Date: